Official Newsletter of the Canadian Public Health Association

CPHA health digest

Summer 2005 Volume XXIX, Number 2

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Canadian Public Health Association 96th Annual Conference

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PRESIDENT'S REPORT

New CPHA Governance Model Approved

In June 2004, as part of CPHA's strategic plan to revitalize and renew CPHA within the context of a dynamic health environment, the CPHA Board agreed to a governance review. A Board Working Group on Governance (BWGG)[1] was established in November 2004 with the mandate to recommend to the Board a proposed governance structure for the CPHA Board of Directors. The review focussed on clarifying the purpose and role of the Board, increasing its engagement in strategy and policy, and improving its core efficiency and effectiveness. An inclusive process involving the membership and the Board was followed over the subsequent 12 months,[2] culminating in an all-day workshop with the Board on June 10, 2005.

I am pleased to announce that on June 11, 2005, the CPHA Board of Directors unanimously approved a new governance model for the Association and notice was served that the by-laws would be redrafted to accommodate these changes.

CPHA's new governance model will:

- move to a skills-based board with a focus both on strategic needs as well as the skills necessary to govern CPHA effectively, while recognizing the importance of geographic and other factors such as gender, ethnicity and age;
- have a smaller number of Board members (maximum of 12), all of whom are voting members;[3]
- introduce new clear role descriptions for the Board, Board members, volunteers, Chair and CEO;
- have a clearer streamlined committee structure with elimination of the Executive Board
  - this will involve introduction of a Nominating Committee, as well as a Board Governance Committee, Business Services Committee and an External Relations Committee;
- enhance Board member capability through
  - increased number of Board meetings
  - reduced term of office to support high levels of participation
  - expectation that Board members participate on a committee or taskforce each year
  - focussed and relevant ongoing Board education process;
- have robust strategies and policy development processes that include the opportunity for external expert engagement. Introduction of an Advisory Council to support the Board in developing strategies around public health issues.[4] The Advisory Council will be composed of the Provincial/Territorial Public Health Association (PTBA) partners and other partner organizations, and will be further developed in consultation with these partners. The Advisory Council will meet at least annually with the full Board to discuss strategic directions and will be responsible for bringing forward some nominations for Board positions.

Sheilah Sommer, President, CPHA

This new model presents continuing and greater opportunities for the PTBAs

see *Governance*, page 3

CPHA Health Digest
Canadian Public Health Association

Volume XXIX, Number 2
Summer 2005

The *CPHA Health Digest*
is an official publication of the
Canadian Public Health Association
and is published four times a year.
It is supplied as a CPHA membership
benefit to members in good standing.

ISSN 0703-5624

Printed on recycled/recyclable paper

Publications Mail Agreement No. 40062779.
Return undeliverable Canadian addresses to:
Circulation Department
Canadian Public Health Association
400-1565 Carling Avenue
Ottawa, Ontario, K1Z 8R1 Canada
Tel: 613-725-3769
Fax: 613-725-9826
E-mail: info@cpha.ca

Executive Managing Editor:
Elinor Wilson, RN, PhD

Coordination & Production:
Ian Culbert

Assistant Editor:
Karen Craven

Circulation:
Joan Barbier

Translation:
Marie Cousineau

Mission Statement

The Canadian Public Health Association is a national, independent, not-for-profit, voluntary association representing public health in Canada with links to the international public health community. CPHA's members believe in universal and equitable access to the basic conditions which are necessary to achieve health for all Canadians.

CPHA's mission is to constitute a special national resource in Canada that advocates for the improvement and maintenance of personal and community health according to the public health principles of disease prevention, health promotion and protection and healthy public policy.

CEO's *column*

One World?

The World Health Assembly recently concluded two weeks of deliberations at its annual meeting, adopting strong resolutions on the public health of the world's population.

The world? Knowing that the World Health Organization, which is the operational arm of the World Health Assembly, has only 192 member countries, how can we say that WHA passed resolutions on the entire population of the world? As the non-governmental representative for Canada, I had the opportunity to participate in those discussions.

What I observed is that WHA recognizes that the world is not divisible, not separable by jurisdictions, boundaries, mountains, oceans, religion, race, income, gross national product, or any of the other categories that we set up as distinguishing ourselves from others. Through coming together to debate and decide public policies on public health issues, the WHA recognizes the need to balance individual needs against societal responsibilities.

WHA recognizes that one case of smallpox, anywhere, is a global disaster; that preventable infectious diseases affect not only one country, but have the potential to impact all – SARS is, of course, a case in point. However, WHA recognizes that less media-appealing infectious diseases are just as important.

In fact, the World Health Organization estimates that rubella (measles) killed 610,000 people around the world in 2002. Rubella is a vaccine-preventable disease. How can Canadians account for the fact that while the United States, with ten times Canada's population, has declared itself a rubella-free nation, Canada had an outbreak of about 250 cases in southwestern Ontario? This outbreak occurred in a largely unimmunized group of people, and most of the cases were children under the age of 19. WHO further estimates that 2.1 million people died of vaccine-preventable diseases in 2002 – and of that, 1.4 million were children under the age of five.

Public health is about continually balancing individual rights against collective responsibility. Under what public health principle should property owners have the 'right' to put pesticides on their lawn? Should individuals have the 'right' to smoke in public places? Should factories or farms have the 'right' to pollute the watershed?

Our world is increasingly interconnected. The WHA debates issues, such as a global immunization strategy, in order to avert millions of deaths every year. Do we too see ourselves as inhabitants of One World?

Elinor Wilson
Chief Executive Officer

Supreme Court Decision and Medicare

Is privatization the only way ahead for Canada's publicly funded health system? The Canadian Public Health Association says "No".

There is another way to sustain our publicly funded health system – we can keep people from getting sick in the first place. This is our shared responsibility, and can help strengthen our collective well-being. No health system is sustainable without increased investments in health promotion, disease prevention and health protection (public health). Unless we can slow the onset of preventable conditions such as infectious diseases, obesity, diabetes, cancer, and heart disease, and reduce the illnesses associated with them, the increased demand for treatment arising from our aging population and our individual expectations for immediate response to personal illness will always surpass our treatment resources.

The question is how to organize the health system in such a way that investments produce the best possible health outcomes for Canadians with the greatest efficiency. A substantial portion of the $42 billion in new federal transfers to provincial governments for the health system must be allocated to public health and prevention.

Sheilah Sommer
President
Canadian Public Health Association

The above letter was submitted to the Globe and Mail on June 11, 2005

Governance, from page 1...

and other partners to be an integral part of CPHA. CPHA will function in an inclusive manner, with the mission of improving personal and community health across Canada, while at the same time focussing on those 'pan-Canadian' issues that will make a difference across the country.

Two phases of implementation

At the June 11, 2005 meeting, the Board appointed an Implementation Task Force[5] to provide leadership for the next phase of the project. The Implementation Task Force will lead a two-phased implementation process:

- **Phase One** (June 2005-December 2005) begins now and includes: the development of a detailed transition plan; the re-drafting and approval by the Board of the by-laws; the development of the detailed nominations process; sharing these changes with membership both before and at the AGM; ensuring a new Board is in place for January 1, 2006.
- **Phase Two** (January 2006-June 2006) includes the more detailed structural and process changes: implementing the new committee structure, and designing the governance processes, including evaluation.

Specific next steps

1. Forming the 2006 Board
   A Transition Nominating Committee (TNC) has been established to implement the process to form the new Board prior to January 1, 2006. The Chair and Chair-Elect have been previously elected. Nominations will be solicited from across the membership based on a strategic skills profile. This call for nominations will go out early in July with the list of possible candidates for election being announced at the time of the AGM on September 20, 2005.
2. By-Law and Policy Changes
   New by-laws will be developed to reflect the approved model. These will be approved by the Board as per the requirements under the current by-laws and shared with members at the upcoming AGM.
3. Developing the Advisory Council
   More detailed design work is required between now and Fall 2005 to flesh out the specifics as to how the Council will function. The first meeting of the Advisory Council is planned for September at the time of CPHA's Annual Conference.

The Implementation Task Force is beginning its work, including the development of a detailed stakeholder communication plan to ensure that members are kept informed and provided with opportunities to comment and give input.

Should you have any questions, please do not hesitate to contact me directly at sheilah.sommer@calgaryhealthregion.ca ■

Notes

1. Membership of the BWGG includes: Sheilah Sommer, Chair of the Board and Chair of the BWGG; Ron de Burger, Chair Elect; Susan McBroom, PTBA representative; Brian Brodie, Member-at-large representative; Peter Glynn, External Expert; Elinor Wilson, CEO; and Janet MacLachlan, Associate CEO, Staff Support.
2. The process included two Board teleconferences with accompanying written materials and two member surveys with written summary reports.
3. Chair, Chair Elect, Student Member, 5 Board Members, 2 Members identified by the Advisory Council (1 PTBA and 1 Organizational Partner) and 2 External Members. The CEO is normally present at Board meetings but is not a member of the Board.
4. The membership of the Advisory Council (AC) will consist of representatives from each of the PTBAs together with those professional partners who have expressed interest. The AC will meet in person at the time of the Annual Conference to consider issues identified by the Board and to provide strategic public health counsel into the issues-based planning process. CPHA will provide content and logistical support.
5. Given the importance of maintaining momentum, it was decided to keep the BWGG membership intact with the exception of the external member.

Working Together Works!

Over the past 12 months, CPHA has worked with several provincial/territorial partners to test two approaches to building multisectoral collaboration. Funded by the Office of the Voluntary Sector at the Public Health Agency of Canada, CPHA and the Heart and Stroke Foundation of Canada worked with the Manitoba Public Health Association; the Newfoundland and Labrador Public Health Association; the New Brunswick/Prince Edward Island Branch of CPHA; the Northwest Territories/Nunavut Branch of CPHA; the Public Health Association of Nova Scotia; and the Yukon Public Health Association.

The "Building Multisectoral Collaboration" project was seen as part of an ongoing process to advance collaboration within and beyond the voluntary public health community. The Project tested two methods to see what is effective in bringing together 'unlikely suspects' on public health issues. One method was a policy capacity tool, and the second was an issue-based focus on unintentional injury prevention.

The three Atlantic-based public health associations collaborated with the Manitoba Public Health Association and focussed on the Policy Capacity tool that had originally been developed by the Public Health Association of Nova Scotia. Through extensive consultation, the public health associations and their partners tested and refined that way of looking at public health. More than 270 participants met in 30 working groups to provide feedback on the tool's content and format, and potential issues arising from it. The consultations brought together regional and urban authorities, federal, provincial and municipal governments, academics, environmental experts, medical officers of health as well as partner organizations in the voluntary sector.

In the North (Yukon, Northwest Territories and Nunavut), about 130 participants representing 80 organizations were consulted about factors relating to multisectoral collaboration with a focus on unintentional injury prevention. The main challenges to collaboration identified across the territories were a lack of resources or support for injury prevention, staff time constraints, funding restrictions, a lack of coordination and leadership, and insufficient communication among services. The Northern project, carried out by the NWT/NU Public Health Branch-CPHA and the Yukon Public Health Association, involved a wide range of stakeholders, including organizations with a direct mandate to provide injury prevention or safety programs; those with a safety component to their work; advocates, and other services providers including government and voluntary organizations.

Keys to success in collaboration

The evaluation report (carried out by Wanda Jamieson of JHG Consulting) noted the following key factors:

- having regional leadership and ownership of activities, with national level support
- having Advisory Committees with the capacity and commitment to provide advice and respond quickly
- tapping into the strength and commitment of public health association volunteers and Project staff, and their ability to be flexible and to find ways to adapt the Project methodology to local circumstances while still staying focussed on common objectives
- being creative in addressing "time crunch" issues, resource challenges, and in building on existing opportunities.

Full reports of the Building Multisectoral Collaboration project can be found at www.cpha.ca ■

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My Internship with the CPHA

A Commitment to Youth Yields a Memory Never Lost

Jonathan Ryan Barry

A memory starts from but one singular moment. Although the moment is passing for me, the memory is just beginning. The Canadian Public Health Association understands the inherent value of today's youth and, therefore, chooses to actively participate in shaping tomorrow's leaders. I have thoroughly enjoyed my internship with CPHA and remain humbled that I was welcomed with such overwhelming hospitality.

I am a third-year undergraduate student at Wake Forest University in Winston-Salem, North Carolina, USA. This past spring I applied for and was selected as a *Pro Humanitate* Scholar. This program funds students who pursue uncompensated internships at non-commercial organizations – such as CPHA – the world over. As a biology major and health policy and administration minor, with aspirations to attend both medical and business schools simultaneously, my proposal to research both

The Canadian HIV/AIDS Information Centre

Taking Action on HIV/AIDS

In 1983, the Canadian Public Health Association (CPHA) was one of the first NGOs in Canada to address the complex issues surrounding HIV and AIDS. Today, over twenty years later, CPHA continues to play a major role in the collection and dissemination of HIV/AIDS information.

Established in 1989, the Canadian HIV/AIDS Information Centre, a program of CPHA, has the mandate to provide information on HIV prevention, care, and treatment to community-based organizations, health and education professionals, resource centres and others with HIV and AIDS information needs in Canada. With funding from the Public Health Agency of Canada (PHAC), the Centre has embarked on a comprehensive strategic planning exercise to define its specific role within the Federal Initiative to Address HIV/AIDS in Canada and within CPHA's governance structure and strategic priorities.

Guiding this strategic planning exercise will be an expert advisory committee consisting of CPHA members representing various aspects of the response to the epidemic, as well as experts in the field of information dissemination and knowledge transfer. Mr. Ron de Burger, former Director of CPHA's AIDS Education & Awareness Program and currently CPHA's President-Elect, will be chairing this advisory committee.

As part of this exercise, a special focus group will be held on Tuesday, September 20, 2005 from 12:00-1:30pm during CPHA's annual conference in Ottawa. This is your opportunity to share your vision for the future of the Information Centre.

If you would like more information on this exciting new initiative, please contact Ian Culbert, Director, Canadian HIV/AIDS Information Centre, at 613-725-3769 or by e-mail at iculbert@cpha.ca.

Stay tuned for updates in future editions of the *CPHA Health Digest.* ■

American and Canadian public health and healthcare systems was accepted.

Working with Dr. Elinor Wilson, I am conducting a survey to assess CPHA members' priorities for public health goals and their experience with preventive practice of healthcare professionals. Once the results are analyzed, they will prove beneficial not only for the CPHA but also for my personal research on which I will present a report at Wake in September 2005.

Although my time in Ottawa is limited, the memories and information I have acquired are infinite. One day I will place my growing knowledge into action, but until that time, I thank all those I have had the pleasure to meet. Additionally, I must thank the many CPHA members who have responded to the recently launched survey (and if you have yet to do so, please accept this as a friendly reminder).

As I leave CPHA, I understand that the organization is working diligently to invest in today's younger generation; such an investment is a sound practice because youth have a desire to learn. Thank you for the opportunity, CPHA! ■

Coming *events*

The Changing Face of Disaster Management – Defining the New Normal
15th World Conference on Disaster Management
The Canadian Centre for Emergency Preparedness (CCEP)
10-13 July 2005 Toronto, ON
Contact: www.wcdm.org

Mapping the Future of Public Health: People, Places and Policies
CPHA 96th Annual Conference
In partnership with the Canadian Institute for Health Information - Canadian Population Health Initiative (CIHI-CPHI) and the Canadian Institutes of Health Research - Institute of Population and Public Health (CIHR-IPPH) and in association with Statistics Canada's 2nd Health Statistics Data Users Conference 2005
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Hosted by Toronto Public Health, and Canadian Institute of Public Health Inspectors, Ontario Branch
25-28 September 2005 Toronto, ON
Contact:
Ron de Burger Tel: 416-392-1356
or Suzanne Shaw Tel: 416-338-1706
E-mail: ciphi2005@toronto.ca

36th Public Health Association of Australia Annual Conference
Successes in Public Health
25-28 September 2005 Perth, Western Australia
Contact: PHAA
E-mail: conference@phaa.net.au www.phaa.net.au

3rd International Conference on Community Health Nursing Research
New Challenges and Innovations in Community Health Nursing
30 September - 2 October 2005 Tokyo, Japan
Contact: www.ics-inc.co.jp/icchnr2005/icchnr2005@ics-inc.co.jp

Employment Opportunity

The Southern African AIDS Trust (SAT) is searching for a new Executive Director, based in Johannesburg, Republic of South Africa. The "Southern African AIDS Training (SAT) Programme" was developed in 1990 and managed by the CPHA. It is supported through a financial contribution from the Canadian International Development Agency (CIDA).

In 2003, as one of the programme's expected results, the 'Southern African AIDS Trust' was established. SAT became a non-profit company in South Africa in 2005, where its regional secretariat is now located. SAT's strategy is to promote, facilitate and support community initiatives to improve and scale up their responses to HIV and AIDS. SAT has nearly 15 years experience of grant making to CBOs and NGOs and operates a south-to-south skills-training, lesson-sharing, mentoring relationship mechanism called 'School Without Walls' (SWW). The SAT vision is to be the lead CBO/NGO support provider in southern Africa.

The deadline for applicants for this position has been extended and will remain open for an indefinite period. For complete details, refer to the SAT website at: www.satregional.org ■

Tobacco Use and Cessation Counselling

Global Health Professionals Survey Pilot Study

Tobacco use is projected to cause nearly 450 million deaths worldwide during the next 50 years.[1] Health professionals can play a critical role in reducing tobacco use; even brief and simple advice from health professionals can substantially increase smoking cessation rates.[2-4] One of the strategies to reduce the number of smoking-related deaths is to encourage the involvement of health professionals in tobacco-use prevention and cessation counselling. But health professionals who smoke send an inconsistent message to patients whom they counsel to quit smoking.

Studies about tobacco use and training as cessation counsellors among health-profession students have been carried out in various countries.[5-8] However, this is the first instance in which this information has been collected cross-nationally by using a consistent survey methodology. The World Health Organization (WHO), the US Centers for Disease Control and Prevention (CDC), and the Canadian Public Health Association (CPHA) developed the Global Health Professionals Survey (GHPS) to collect data on tobacco use and cessation counselling among health-profession students in all WHO member states. This article summarizes findings from the GHPS Pilot Study, which consisted of 16 surveys conducted in 10 countries among third-year students in four health-profession disciplines (dentistry, medicine, nursing and pharmacy) in early 2005.

GHPS is part of the Global Tobacco Surveillance System (GTSS). GHPS uses a core questionnaire on demographics, prevalence of cigarette smoking and other tobacco use, knowledge and attitudes about tobacco use, exposure to secondhand smoke, desire for smoking cessation, and training received regarding patient counselling on smoking-cessation techniques. The GHPS Pilot Study surveyed third-year students from Albania (dental, medical, nursing and pharmacy), Argentina (Buenos Aires) (medical), Bangladesh (dental), Croatia (medical), Egypt (medical), Federation of Bosnia and Herzegovina (nursing), India (dental), the Philippines (pharmacy), the Republic of Serbia (Belgrade) (dental, medical and pharmacy), and Uganda (medical and nursing). GHPS follows an anonymous, self-administered format for data collection. The questionnaires were translated into local languages as needed.

The findings indicated that current cigarette smoking (defined as those who reported that they currently smoke daily or occasionally) among these students was higher than 20% in 7 of the 10 countries surveyed. Current cigarette smoking among third-year health-profession students was most prevalent in Albania, Argentina, Bangladesh, Croatia, Federation of Bosnia and Herzegovina, the Philippines, and the Republic of Serbia, with rates ranging from 18.1% (Republic of Serbia [Belgrade] medical students) to 47.1% (Albania pharmacy students). The lowest current smoking prevalences were reported among Ugandan nursing (0.5%) and medical (2.8%) students, Egyptian medical students (7.9%), and Indian dental students (9.6%). Male students were significantly more likely than female students to currently smoke cigarettes in Albania, Bangladesh, Egypt, India, Philippines, Republic of Serbia (Belgrade) (medical students only), and Uganda. Only among Serbian dental students were females significantly more likely than males to currently smoke cigarettes.

A very high proportion (ranging between 87%-98%) of the students surveyed believed they should have a role in counselling patients to quit smoking. But a minority, ranging between 5%-37%, of these third-year students had actually received formal training in how to conduct such counselling. More than 90% of third-year students in every survey except medical students in Croatia thought health-profession students should receive cessation counselling training as part of their normal curriculum.

Findings from the 2005 GHPS Pilot Study suggest that the public health community should target cigarette smoking among health-profession students because this behaviour endangers their own health and reduces their ability to deliver effective anti-tobacco counselling to their patients. The findings in this report also indicate that most third-year health-profession students in the countries surveyed did not receive formal training in smoking cessation counselling, even though more than 90% of the same students want such training to be included in their formal curricula. All health-profession schools, public health organizations, and education officials should discourage tobacco use among health professionals and work together to design and implement programs that train all health professionals in effective cessation-counselling techniques.

GHPS provides countries with a way to measure tobacco use among health-profession students, the desire for cessation among students who smoke, the extent to which students are being trained to provide tobacco-cessation counselling, and the willingness of students to use such training to reduce tobacco use among their patients. The GHPS Pilot Study proved successful in terms of school and student participation, fieldwork procedures, data collection, cost, and reliability of data. In light of these successes, GHPS will be expanded over the next year to include approximately 40 additional countries. The goal of WHO, CDC and CPHA is to gather data from all four disciplines in as many of the 192 WHO member states as possible by the end of academic year 2008. ■

The original article appeared in the MMWR 2005;54:505-9, and was adapted for the CPHA Health Digest and reproduced with the permission of the US Centers for Disease Control and Prevention. For additional information about the GHPS and CPHA's international tobacco control efforts, contact James Chauvin at: jchauvin@cpha.ca

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Canada's International Immunization Initiative

The #1 Ladies Polio Eradication Team

Melanie Galvin

I had the good fortune to spend three months in Botswana working for the Stop Transmission of Polio (STOP) project in the fall of 2004. At the time, Botswana had recently detected its first polio case since 1991. This case illustrated how challenging the last few years of polio eradication will be, since every country is still at risk while any country has the virus.

Botswana is a lovely, peaceful country whose economy is basically supported by diamonds. It has recently enjoyed a huge upsurge in tourist popularity as a result of the best selling #1 Ladies Detective Series, by Alexander McCaul Smith. Longstanding good governance has created an exceptionally strong health and education infrastructure. The health system is outstanding in many ways. There are 24 health districts, each with a public health team. Nearly all villages have clinics, all of which are staffed with Registered Nurses, many of whom are also midwives. Adequate funding means that clinics all have full stocks of medicines including antibiotics. With very few exceptions, all clinics have vehicles used to pick up supplies, conduct mobile visits and transport patients to the hospitals if necessary.

A clever program designed to ensure healthy babies requires that mothers bring their children to their local clinic once a month for weighing and to receive food rations for the children at the same time. This system ensures that the health records of infants are reviewed monthly; consequently, immunization coverage levels are generally in the 80 to 90% range, levels very difficult to achieve in many countries.

Even this excellence in health care delivery did not provide full protection from the polio virus. The highly sensitive surveillance system did pick up a case and the laboratory tests revealed the virus to be imported from the 2004 outbreak in Nigeria. This was a surprise, given that most of the importation from the Nigerian outbreak had to date been confined to the countries surrounding Nigeria. Between Botswana and Nigeria, there were many unaffected countries.

PHOTO CREDIT: MELANIE GALVIN

Clinic team posing by the original village clinic.

Polio spreads rapidly and easily. Virus can be shed for months in rare cases, long after what is often a mild illness (paralysis occurs in less than one in a hundred cases). Much activity followed detection of the case in Botswana, with supplemental immunization activities for the entire country occurring very shortly thereafter. There have been no further cases.

It is a testament to the exceptional nurses who run the clinics in Botswana that surveillance and outbreak response are so good. They are the first line in community surveillance and they take the job seriously. Monthly workshops at the District Health team offices, with high attendance given the availability of cars and well-maintained roads, allowed for quick and effective refresher courses on polio once it was established that there was a case in the country. Nurses are generally the first to see a patient; if they suspect polio, they most often transport the child to the local primary care hospital for review by a physician, or call in the Public Health Specialist.

Our STOP team was responsible for reviewing routine immunization activities in districts where coverage was lower. We conducted many workshops designed to teach the clinics to monitor their own coverage and thereby identify areas of potential weakness. The nurses were so enthusiastic and it was a privilege to visit the clinics and talk with them. I can't say I saw a lady detective in Botswana, but I sure found the #1 Nurses Polio Eradication Team there.

Even in this lovely place, with its enviable health system, polio can take hold. Because of the exceptional immunization coverage and well-entrenched surveillance system, polio inflicted little damage where a less-resourced country might have found itself easily overwhelmed by cases. Yet, until polio is eradicated, no country is really safe. ■

On a Bridge to Bosnia

Hannah Cowen, RN

Canada has had a constructive impact on the capacity of South Eastern Europe to respond to HIV through a variety of technical assistance missions. These were funded by CIDA through a regional HIV/AIDS project in the Balkans region implemented by UNICEF and with Canadian resources mobilized by the Canadian Public Health Association. It was my recent good fortune to be part of this project. Between March 10-21, 2005, I taught 16 nurses in Bosnia-Herzegovina (BiH) about VCCT – voluntary confidential counselling and testing for HIV.

Nurse colleagues at the HIV outpatient clinic in London, Ontario use the bridge as a symbol for their work – a bridge connects different places; the traffic flows back and forth; and it can be built to span barriers that appear insurmountable. Both Ottawa and Sarajevo are cities of many bridges. The regional HIV project seems like a bridge to me – connecting people who are different in many ways yet united in our struggle against the harm of HIV in our world.

My trip had several components – the actual teaching took place over four days; two days provided opportunities to meet with doctors, nurses and a patient in the HIV care and prevention system; and a weekend on either end gave me time to explore a bit of the city and countryside around Sarajevo and take a day trip to another city, Mostar.

A useful exercise asked participants to list some concerns about doing HIV work, goals for the workshop, and strengths they have to help them do the work. The conversation was lively and luckily their goals reflected what the teaching plan had in it! These nurses' concerns included the possibility of infection thorough work; the lack of PEP (post-exposure prophylaxis in case of an accidental risk for HIV); the societal and familial discrimination faced by their clients; the lack of care for self and society they perceived in people with addictions; how they could make their work places and their own actions welcoming to people in risk groups; how to ensure confidentiality; how to do prevention with the highest risk people; and, how to deliver reactive test results.

They identified strengths such as: they had decided to accept the work, wanted to help limit the spread of HIV and take care of infected people; they had high tolerance of all types of people; this was part of their profession and they were proud of being nurses; they were aware of conditions in their country that might lead to rapid spread of HIV; and, they wanted to keep the number of cases low. Their hopes for the training included: an increase in knowledge and practice of techniques for prevention and for delivering results, especially reactive results; how to protect themselves; how to build client trust; how to give high quality counselling; and, how to teach/mentor their colleagues.

Evaluations indicated nurses were pleased with the knowledge and skills practice. It was a lot of material in a short time and they would have appreciated the facilitator demonstrating a role play first to give an example before they started. They wanted even more stories from my practice. For me, the rapidly warming interaction among the participants and their exchange of contact information so they can have a network of support is one of the outstanding benefits of such workshops. I shared information about the Canadian Association of Nurses in AIDS Care, in which nurses support nurses to give high quality care.

Throughout the course, I kept a list of "issues arising". At the end of the workshop, we looked at next steps they could take in their own personal and professional lives as well as ideas to include in the report to UNICEF and CPHA. We identified several needs: addictions services especially for young people; safe housing for youth alienated from their families; consistent country-wide provision for PEP for healthcare providers; more counselling services. All of these were issues with which I could relate in my work as a nursing specialist in HIV/AIDS at the OASIS clinic in Ottawa. Although the nurses did not raise overwork issues, I found it to be an issue, especially for hospital nurses, when I had the opportunity to tour an Infectious Diseases ward and the nurses described their usual caseload as 30 in-patients, most of the time for one nurse.

The nurses brain-stormed solutions as well: they considered underused resources such as unemployed trained nurses and what their role could be; future workshops like this one; and more training on responding to addictions and harm reduction. There was also interest in training and policies on confidentiality and what Canadian organizations and clinics do with respect to quality assurance around confidentiality.

Another honour for me was to have time to discuss the struggle against HIV with Dr. Jelena Ravlija, from the Federal Institute of Public Health. It was a chance to bring forth the solutions, strengths and concerns from the workshop, and to hear how many of the issues are already being worked on, including hospital workload and what role unemployed nurses might fill. Part of the learning I brought home was how her office has nurtured and turned around a previously non-productive relationship with the media on the HIV/AIDS issue.

This was a rich teaching and learning opportunity. As Canada continues its global work against HIV, our work abroad enhances our work at home. I left with many contacts in case of problems or for interest. Talking with Canadians who have lived or visited in BiH was helpful. Other parts of my preparation involved talking with two people from BiH now living in Ottawa and internet research gathered by my husband. The greatest sources of help were two other nurses who had conducted similar missions, Lorette Madore of Ottawa's Public Health Department and Daphne Spencer from the British Columbia Centre for Disease Control in Vancouver. They generously shared their presentations, their impressions, advice and encouragement.

Thank you, CPHA, for the chance to participate. ■

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"Partners Around the World" is undertaken with the financial support of the Government of Canada provided through the Canadian International Development Agency (CIDA).